STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street, Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Office of Preparedness & Response
Sherry Adams, R.N., C.P.M, Director
Isaac P. Ajit, M.D., M.P.H., Deputy Director

October 22, 2010

Public Health & Emergency Preparedness Bulletin: # 2010:41
Reporting for the week ending 10/16/10 (MMWR Week #41)

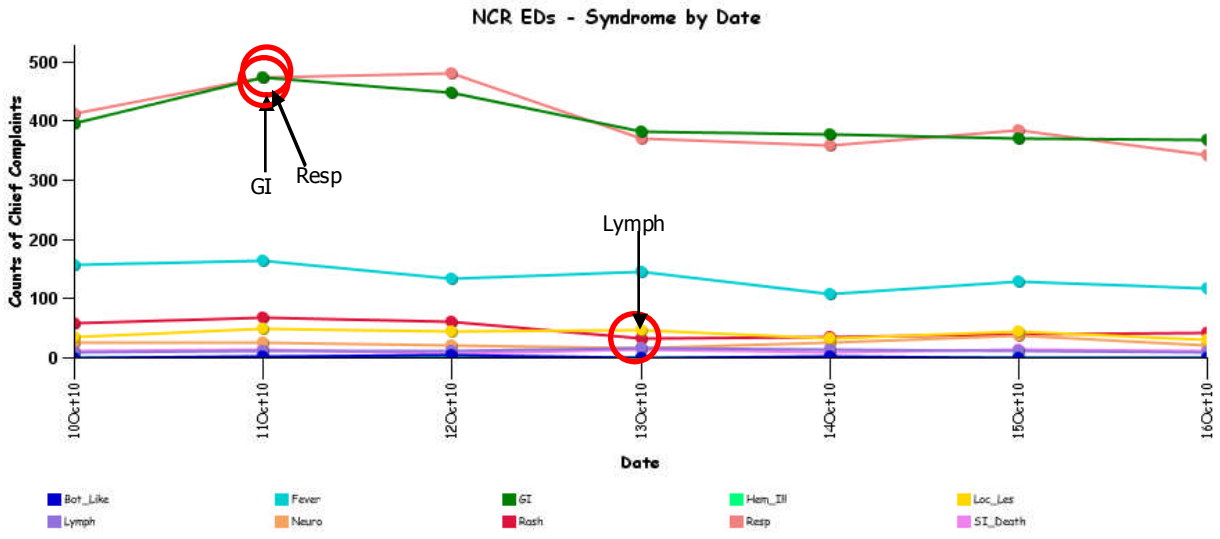
CURRENT HOMELAND SECURITY THREAT LEVELS

National: **Yellow (ELEVATED) *The threat level in the airline sector is Orange (HIGH)**
Maryland: **Yellow (ELEVATED)**

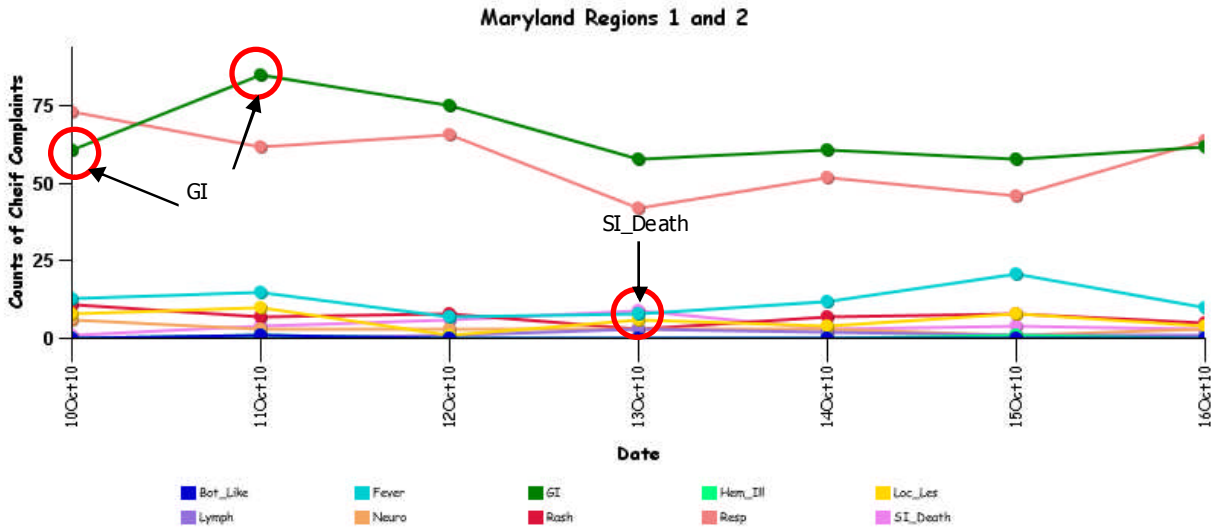
SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR Spring 2006 (v 1.3) now uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

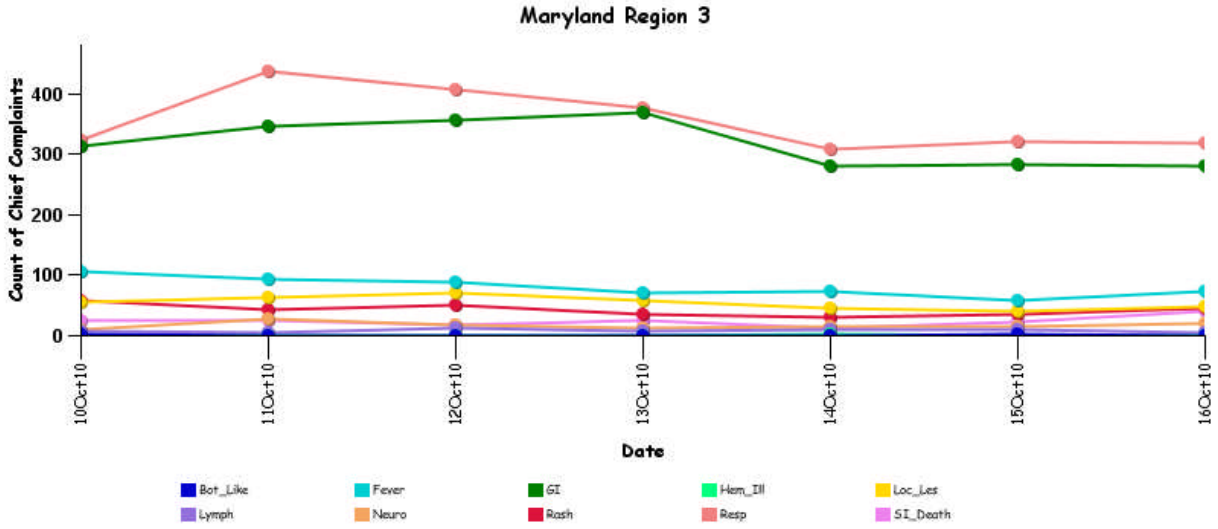
MARYLAND ESSENCE:



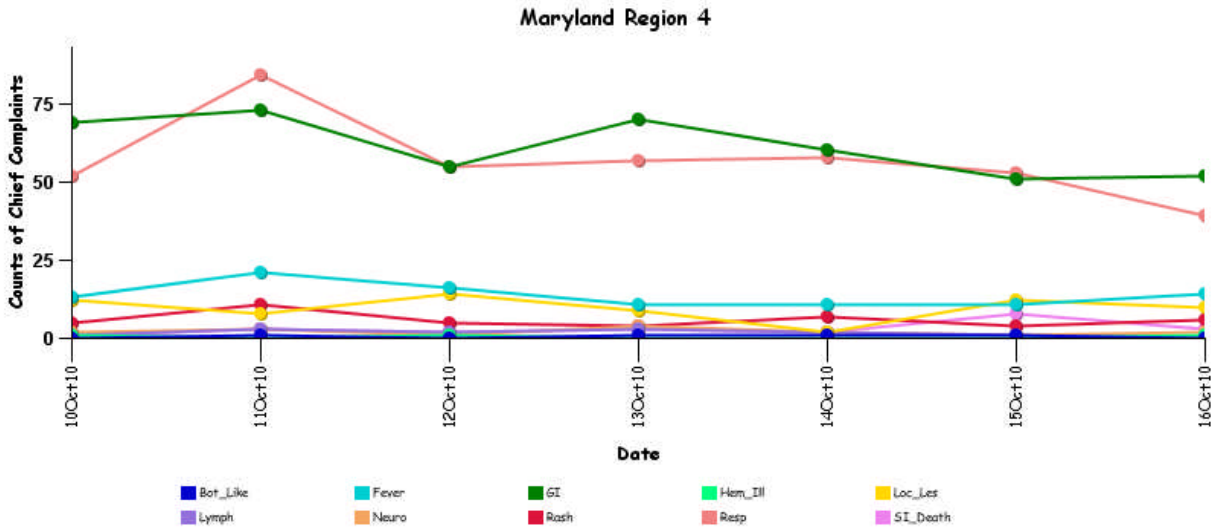
*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE



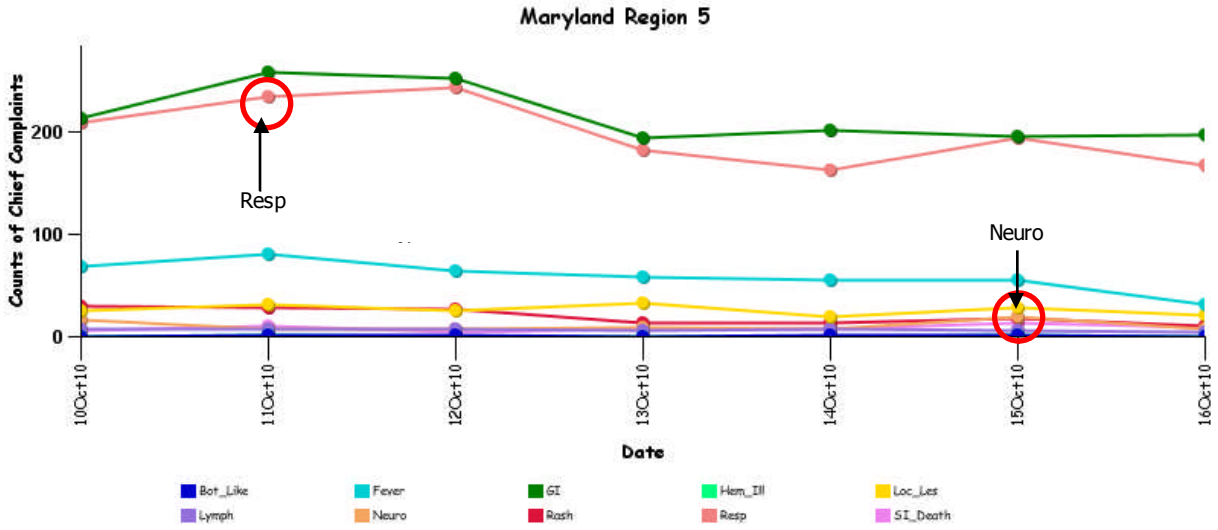
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



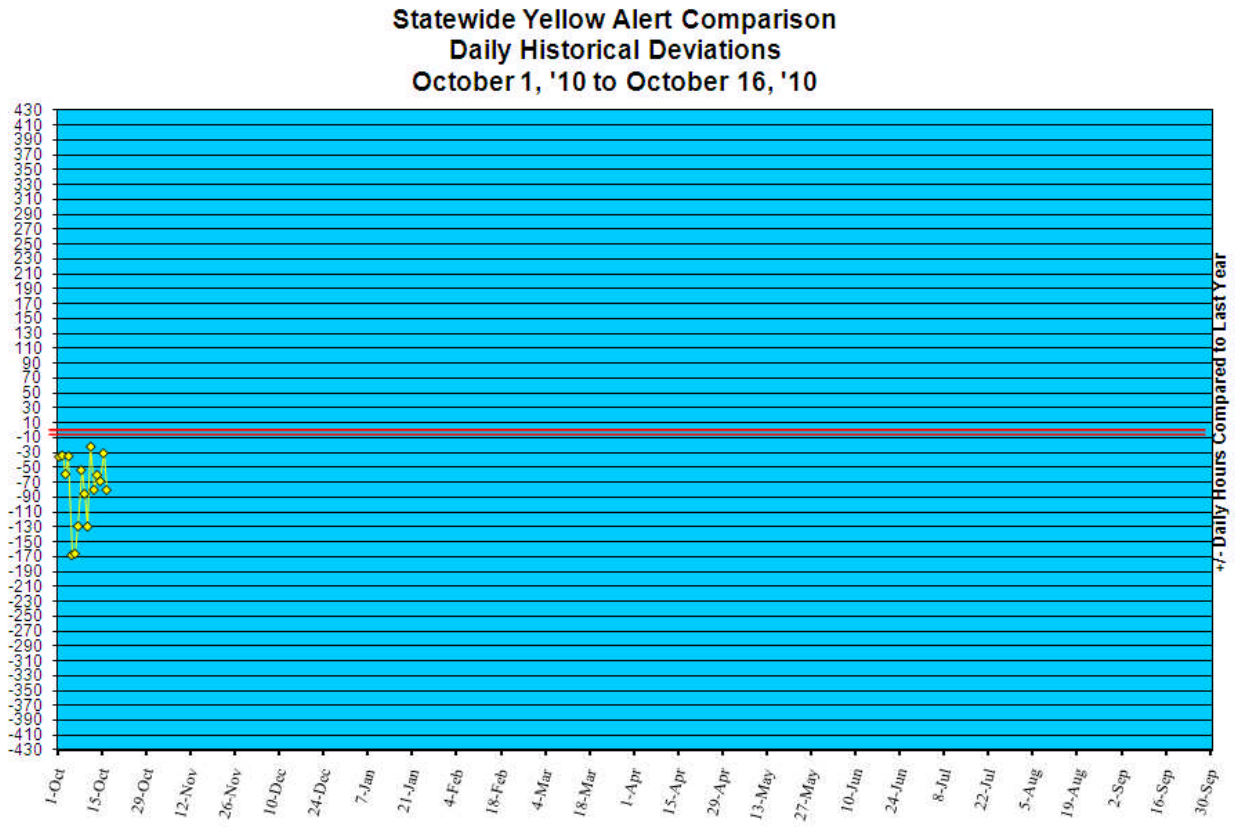
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/10.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in September 2010 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (October 10– October 16, 2010):	16	0
Prior cases (October 03– October 09, 2010):	21	0
Week#41, 2009 (October 11 – October 17, 2009):	16	0

2 outbreaks were reported to DHMH during MMWR Week 41 (October 10 – October 16, 2010):

1 Gastroenteritis outbreak
1 outbreak of GASTROENTERITIS in a Daycare

1 Foodborne gastroenteritis outbreak
1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Food Service Facility

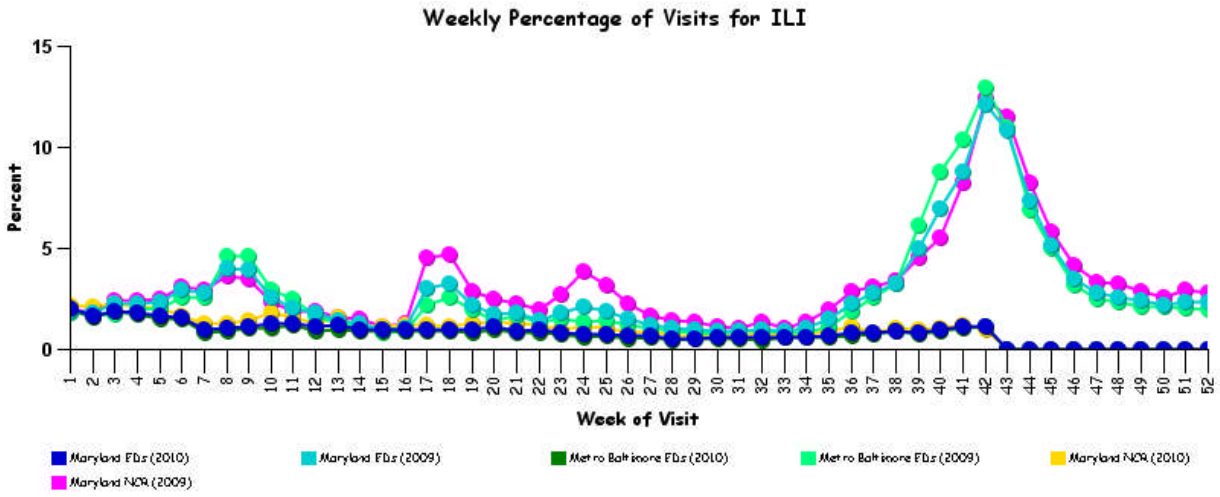
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity was sporadic for Week 41.

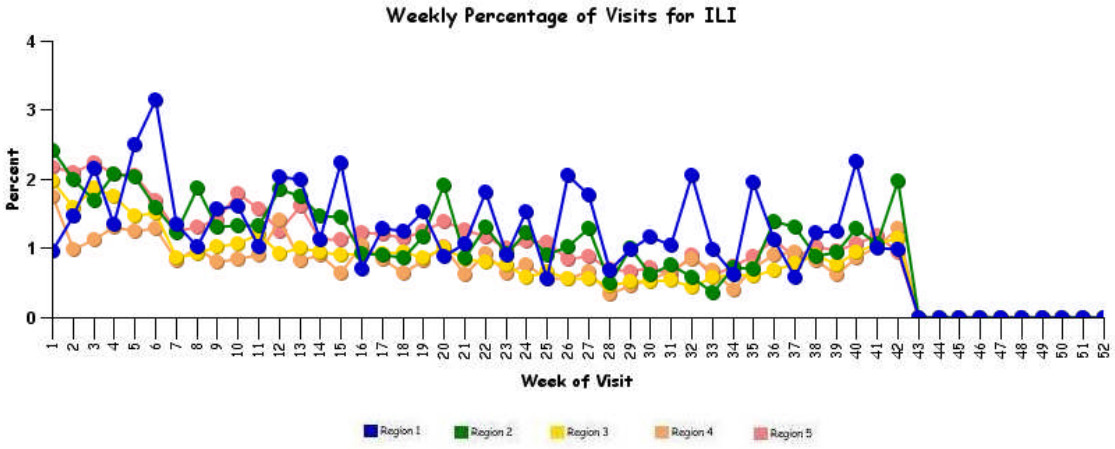
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



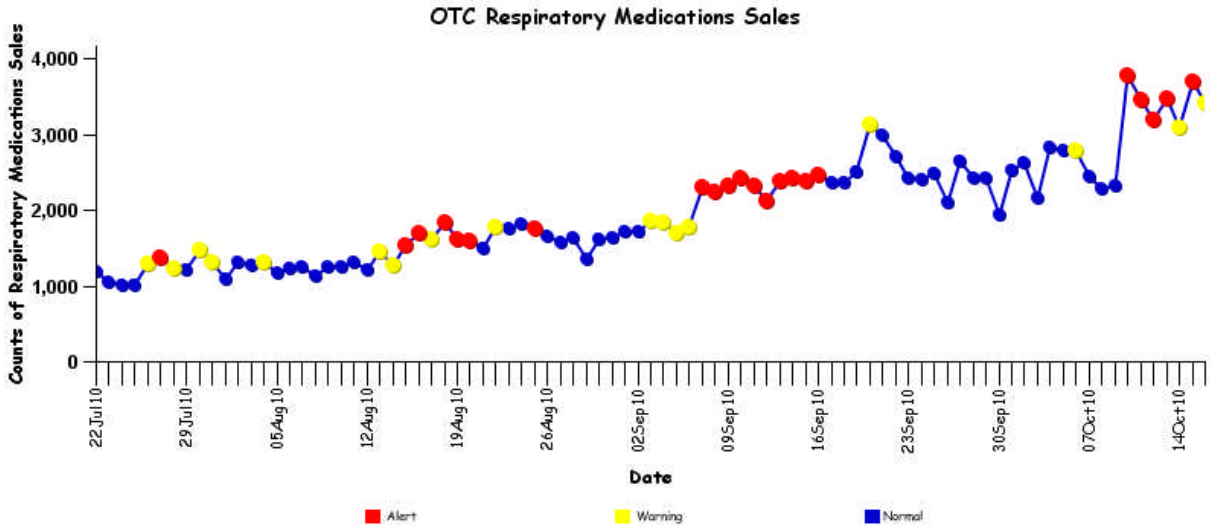
* Includes 2009 and 2010 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2010 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

As of August 31, 2010, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 505, of which 300 have been fatal. Thus, the case fatality rate for human H5N1 is about 59%.

AVIAN INFLUENZA, HUMAN, SUSPECTED (INDONESIA): 16 Oct 2010, A 9-year old girl is suspected of [having contracted] bird flu [avian influenza A(H5N1) virus infection]. The patient was admitted to the bird flu/swine flu isolation unit of the Dr Soedarso Hospital at 11:30 pm on Mon 13 Sep 2010, according to Dr Tita Selati Sundari, spokesperson for the Dr Soedarso hospital. The patient, who is a resident of Jalan Padi, Pontianak city, had signs/symptoms of avian A(H5N1) virus infection and had direct contact with birds. Chickens reared in the patient's house were reported to have suddenly died before she started to develop fever. In the meantime, the Dr Soedarso Hospital has collected throat swab samples from the patient to be sent to a Ministry of Health laboratory in Jakarta. The patient is recovering, and her temperature has fallen. The result of the diagnostic testing in Jakarta is awaited, said Dr Tita. This patient is the 2nd suspected bird flu case treated at the Dr Soedarso Hospital within past 2 months.

NATIONAL DISEASE REPORTS

EASTERN EQUINE ENCEPHALITIS (FLORIDA): 15 Oct 2010, A Dunnellon area horse has died of eastern equine encephalitis, according to the Marion County Health Department. It was the 5th horse in the area to die of the mosquito borne illness, which is usually fatal to horses and can be fatal to humans. In horses, the disease presents itself as a general lethargy and depression-like signs. Occasionally vaccinated horses die of the disease. (Viral Encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

EASTERN EQUINE ENCEPHALITIS (OHIO, NEW YORK): 12 Oct 2010, In what has been a long, hot, dry summer, more cases of eastern equine encephalitis (EEE) have been confirmed in Ohio and New York recently. Two horses were euthanized in Ohio, bringing the total for EEE cases in that state to 4. Williams and Sandusky counties each have had 1 case in the past couple of weeks, while Mercer County reported 2 cases earlier this year [2010]. In Vernon, New York, a yearling colt was euthanized after

displaying clinical signs of EEE on 7 Oct 2010. He first exhibited signs in late September and the New York Department of Health's Wadsworth Laboratory confirmed EEE. This was the 1st confirmed case in Oneida County since 2006, but the 7th case in New York this year (the 1st New York case was confirmed in August 2010). Other New York counties that have had horses euthanized due to EEE include Madison (1), Oswego (2), and Onondaga (3). "The hot summer weather provided ideal breeding conditions for mosquitoes resulting in higher than normal instances of arboviruses including eastern equine encephalitis and West Nile virus throughout New York state," health director Gayle Jones told the Rome Sentinel. Eastern equine encephalitis is caused by a virus that can infect birds, horses, and humans. It is transmitted by mosquitoes, and outbreaks typically occur in late summer and early fall when mosquitoes are most abundant. Infected horses could experience symptoms including paralysis, impaired vision, difficulty swallowing, hanging their heads, and grinding their teeth. (Viral Encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS

CRIMEAN-CONGO HEMORRHAGIC FEVER (PAKISTAN): 16 Oct 2010, A total of 4 more people have been diagnosed with Crimean-Congo hemorrhagic fever (CCHF) at Ayub Medical Complex, Abbottabad. Reports received from National Institute of Health (NIH) on Tue 12 Oct 2010 confirmed that the patients were suffering from CCHF. Ironically, all 4 patients were discharged a few days ago and the hospital is unaware of their whereabouts. Talking to the Express Tribune, deputy medical superintendent (DMS) Dr Junaid said the hospital had sent 8 blood samples to National Institute of Health, 4 of which tested positive for CCHF [virus infection]. He said the 4 patients had been admitted in medical ward A of Ayub Medical Complex Hospital but were discharged a few days ago because "their condition did not seem serious". The hospital administration does not have addresses of the patients, however, he said that 2 of them belonged to Mansehra, one was from Rajoya village in Havalian, while the whereabouts of the [3rd and] 4th patients are unknown. Sources inside the hospital said the pathology department was responsible for maintaining records of these patients. They said a young resident medical officer (RMO) of ATH [Ayub Teaching Hospital] died of the disease a few days back. Since [the doctor's death] the hospital received 16 patients suspected [to have contracted] CCHF and their blood samples were sent to NIH for tests. All these patients were admitted in the hospital's medical ward A and later discharged, sources said. The ATH administration has constituted a team including DMS Dr Junaid, Professor Dr Shamim Anwar and Professor Dr Javed, who, after holding a meeting with a World Health Organization representative, have established quarantine measures for CCHF patients in the ATH and arranged 500 protective kits. "Beside lab procedures, early identification of the disease is very important," said Dr Athar Lodhi, director of IPP and Planning at ATH. [A] quarantine area to treat such patients has been established next to the IPP ward, which is putting other patients at risk. "I have requested the chief executive of the hospital to shift the quarantine to a safer location," he added. (Viral Hemorrhagic Fever is listed in Category A on the CDC list of Critical Biological Agents) *Non-suspect case

JAPANESE ENCEPHALITIS (INDIA): 14 Oct 2010, In Gorakhpur during the last 24 hours, 4 people succumbed to encephalitis at Baba Raghav Das Medical College hospital [BRD MCH], taking the death toll to 414 in the eastern region of Uttar Pradesh, a health official said on Wednesday [13 Oct 2010]. Additional director (Health) UK Srivastav said the dead include one each from Gorakhpur, Mahrajganj, Gonda, and Ballia districts. A total of 34 new patients have been admitted to this hospital during the same period, he said. Of the total 414 deaths so far, 386 deaths occurred in BRD MCH while the remaining were reported from other state-run hospitals of the region Gorakhpur, Basti, Deoria, Siddharthnagar, Kushinagar, and Maharajganj districts. As many as 290 patients are presently undergoing treatment at the BRD MCH and 19 in other government hospitals for the disease, he said. (Viral Encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

UNDIAGNOSED FATAL ILLNESS (INDIA): 13 Oct 2010, The total toll from "mysterious" fever has continued to escalate with 13 more deaths reported from Ramabai Nagar district ([formerly] Kanpur Dehat) on Sunday [10 Oct 2010]. More and more people infected with the unidentified virus have flocked the district hospital in Akbarpur. So far, 256 people have already died during the past few days. A team of district officials visited the affected villages on Sunday [10 Oct 2010] to ascertain the facts and figures of human casualties. It has been learnt during the visit that as many as 400 people, most of whom are minors, are down with fever. The disease started from Ahrauli Sheikh village in Amraudha block and within a month spread to 48 villages, housing 3000 families. It was also learnt that the infants who fell victim to the disease were suffering from acute malnutrition. "The infants were suffering from malnutrition and that made some of them vulnerable to the killer virus," said district nodal officer (epidemic) Arvind Sachan. (Emerging Infectious Disease is listed in Category C on the CDC list of Critical Biological Agents) *Non-suspect case

CHIKUNGUNYA (CHINA): 12 Oct 2010, From 1-5 Oct [2010], 15 new confirmed cases of chikungunya fever, an insect borne virus, appeared in Dongguan City. The Department of Health of Guangdong Province reported on the evening of 6 Oct [2010] that as of 4:00 p.m. on 5 Oct 2010, 204 total cases of the virus [infection] had been reported, 38 of which had been confirmed by a laboratory and 166 suspected, awaiting verification. At present, all cases were mild. The patients are in stable condition and there have been no severe cases or deaths. (Emerging Infectious Disease is listed in Category C on the CDC list of Critical Biological Agents) *Non-suspect case

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a

definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

Sadia Aslam, MPH
Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-2074
Fax: 410-333-5000
Email: SAslam@dhmh.state.md.us

Zachary Faigen, MSPH
Epidemiologist
Office of Preparedness and Response
Maryland Department of Health & Mental Hygiene
300 W. Preston Street, Suite 202
Baltimore, MD 21201
Office: 410-767-6745
Fax: 410-333-5000
Email: ZFaigen@dhmh.state.md.us